DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Michigan Department of Community Health

FAX: 517-335-0075

☐ Medicaid ☐ CSHCS

Note: Approval refers to service only and does not authorize fees or patient eligibility, including age.

For MDCH Consultant Use Only

1. Prior Authorization No.							
2	3	4	5	6	7	8	9

10. Provider Name (Last, First, Middle Initial)			17. Recipient Name (Last, First, Middle Initial)		
11. Provider Street Address		12. Provider County	18. Recipient Street Address		19. Birth Date / /
13. City	State	ZIP Code	20. City	State	ZIP Code
14. Prov. Type / 15. Provider ID No.		16. Provider Phone No. ( ) -	21. Sex ☐ M ☐ F / 22. Recipient ID No.		23. Recip. Phone No. ( ) -
24. Does Patient Live in a Nursing or AIS Home? ☐ No ☐ Yes ➢			If Yes, Facility Name		Facility Phone No. ( ) -
25. Is Patient Covered by Any Other Dental Plan? ☐ No ☐ Yes ➢			If Yes, Plan Name		

26. Indicate Missing Teeth with an "X".

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

27. Are X-Rays Enclosed? ☐ No ☐ Yes ➢ If Yes, Number of X-Rays

28. Is Treatment for Orthodontics? ☐ No ☐ Yes

29. How Long Has Patient NOT Worn a Prosthesis?

30. How Long Has Patient Been Edentulous?

31. Other Pertinent Dental or Medical History:

EXAMINATION AND TREATMENT RECORD

LINE	32. Tooth	33. Surface: M D O L I F	34. Procedure Code	35. Consultant Use Only	36. Description of Service
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37. Status of Current Prosthesis:

	Part	Full	Date Inserted	Can Be Worn Yes	Can Be Worn No	Can Be Repaired Yes	Can Be Repaired No	Used Now Yes	Used Now No
Max				☐	☐	☐	☐	☐	☐
Mand				☐	☐	☐	☐	☐	☐

38. Reason for Denture Replacement:

39. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Signature Date:

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40. Consultant Remarks:

41. Request Approved As:

1	5	Presented	4	8	Disapproved
2	6	Amended			No Action

42. Consultant Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if payment from applicable Program is sought.

The Department of Community Health is an equal opportunity employer, services and programs provider.

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